Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		NVN4564AGC		A. BUILDING B. WING		C 07/12/2010		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	<u> </u>		
ITM CROUP CARE			1435 AKAR RENO, NV	IKARD DRIVE NV 89503				
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
Y 000	Initial Comments			Y 000				
Y 895 SS=C	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Initial Comments  The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.  This Statement of Deficiencies was generated as a result of a complaint investigation and observations reported by Agency #1 on 7/12/10 and by the authority of NRS 449.150, Powers of the Health Division.  The facility is licensed for eight Residential Facility for Group beds for elderly and disabled persons, Category II residents.  The following deficiencies were identified:  Complaint #NV00025861 was substantiated. See Tag Y895, Tag Y920 and Tag Y923.		d as s, ral, ed as 2/10 rs of led . See	Y 895				
	or otherwise misses, medication; and (4) Instructions for	an administration of						

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		` '	(X3) DATE SURVEY COMPLETED C	
		15211111167111611116	IDENTIFICATION NOMBER.		A. BUILDING			
NVN4564AGC				B. WING		07/12/2010		
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
JTM GROUP CARE			1435 AKARD DRIVE RENO, NV 89503					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
Y 895	Continued From pag	e 1		Y 895				
		ident that reflect the cu of the resident's physic						
Y 920	Based on reported of facility failed to ensure administration record medication administration Severity: 1 Scope:	I (MAR) was initialed for ation on 6/24/10.	1, the	Y 920				
SS=F	NAC 449.2748  1. Medication, includ over-the-counter medication are stored at a residential facility must be stored area that is cool and caregivers employed shall ensure that any medical or diagnostic may be misused or a resident or any other person is protected. External use only mulocked area separate medications. A reside of administering medication in his roo	d in a locked dry. The by the facility medication or equipment that appropriated by a unauthorized Medication for st be kept in a from other ent who is capable lication to himself nay keep his	ny					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
	NVALAFOLAGO			B. WING		C <b>07/12/2010</b>		
NAME OF PR	OVIDER OR SUPPLIER	NVN4564AGC	STREET ADD	ESS. CITY. STA	ATE, ZIP CODE	07/12	2/2010	
ITM CROUD CARE				ADDRESS, CITY, STATE, ZIP CODE  KARD DRIVE  NV 89503				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ACTION SHOULD BE TO THE APPROPRIATE		
Y 920	Continued From page	2		Y 920				
	medication is kept in a container for which th been provided a key.	a locked						
	Based on observation 6/25/10, the facility fa belonging to the resid locked container.	t met as evidenced by: as reported by Agency a iled to ensure medication ents were secured in a	#1 on ons					
	Severity: 2 Scope 3							
Y 923 SS=F	449.2748(3)(b) Medic	ation Container		Y 923				
	NAC 449.2748 3. Medication, including over-the-counter med supplement, must be: (b) Kept in its original administered.	•	ny					
		l containers until						